A. SUMMARY OF FUNDING REQUEST.

The Massachusetts Department of Public Health (MDPH) is applying for both Components I and II. The Component I plan described below is designed to help MDPH improve agency-wide performance management, develop quality improvement projects within selected bureaus and stimulate and support quality improvement projects at selected local health departments. The proposed activities are expected to improve the performance of state and local public health in all four key areas.

These activities include: (1) Designation of the MDPH Commissioner's senior policy advisor as Performance Improvement Manager, working with the MDPH Director of Program and Policy and a performance improvement specialist from Commonwealth Medicine to oversee and coordinate all Component I activities. (2) Designation of bureau-level Quality Management Leaders (QMLs). (3) Quality improvement training for the MDPH senior management team, bureau directors and QMLs. (4) Participation in national training and networking. (5) Assessment of opportunities and definition of measures for improved performance management. (6) Activities to support accreditation readiness (state strategic plan, health assessment and health improvement plan, education of local boards of health). (7) Quality improvement projects focused on winnable battles in public health and the four key areas. (8) Support for quality improvement projects at selected local health departments.

Component I performance improvement and QI activities will support, though they do not duplicate, the specific objectives and activities in Component II – which focus on building local public health capacity through regional collaboration, improvements in surveillance and monitoring systems and increased access to data for local public health assessment.

B. BACKGROUND.

(1) Need: The proposed Component I performance improvement activities are designed to support the five strategic priorities of the Massachusetts Department of Public Health. MDPH has worked hard in recent years to identify its overarching strategic priorities, allowing us to focus our efforts, identify policy opportunities and improve results. These priorities were developed collaboratively in 2007 with input from hundreds of residents, stakeholders and community partners who attended regional meetings around the state. These goals reflect the issues that define public health in the 21st century. In its programs and policies, MDPH is committed to:

- Ensuring the success of Health Care Reform.[1]
- Eliminating racial and ethnic health disparities.
- Promoting wellness in the workplace, school, community and home.
- Managing chronic disease.
- Building public health capacity at the local and state levels.

These priorities are closely aligned with the "key areas" outlined in the funding announcement for Strengthening Public Health Infrastructure for Improved Health Outcomes.

In the wake of the state's landmark health care reform law, Massachusetts has the lowest rate of uninsured residents in the nation. It is a national innovator in such areas as tobacco

[1] Initially focused on the state's health reform legislation, but now incorporating national health reform.

control, HIV prevention, and strategies to address health equity. But the health of the state's 6.6 million residents is compromised by significant gaps in the public health infrastructure. These include fragmentation and lack of capacity among the state's 351 local health boards, the incomplete reach of key statewide surveillance and monitoring systems, the need for more easily accessible health data to inform policy and practice at both the state and local level, and the need for strengthened performance monitoring and quality improvement, particularly in areas such as foodborne disease, HIV, obesity and health equity, where substantial and potentially historic progress is within our grasp.

As the state that went first and farthest in health care reform, Massachusetts is a laboratory for addressing the opportunities and challenges of national health reform: seeing to it that insurance coverage translates into health care; working to integrate prevention into primary care; addressing challenges in heath care capacity and cost; and developing a public health infrastructure at both the state and local level which is fully capable of meeting its obligations in the coming transformation of health care.

(2) Goals and objectives: The overall goal of the Massachusetts Component I project is to systematically increase the performance management capacity of state and local public health to ensure that public health goals are effectively and efficiently met, and that the promise of health care reform is fully realized. To achieve this goal, the project has the following objectives:

Objective 1. Performance Management Leadership: Improve agency-wide MDPH performance management:

(a) By Month 1, designate the MDPH Commissioner's senior policy advisor as Performance Improvement Manager, working with the MDPH Director of Program and Policy and a performance improvement specialist from Commonwealth Medicine to oversee and coordinate all Component I activities.

(b) By Month 4, designate bureau-level Quality Management Leaders (QMLs).

(c) Starting in Month 6, conduct quality improvement training for the MDPH senior management team, bureau directors and QMLs.

(d) Participate in national training and networking, ongoing throughout the project period.

(e) By Month 9, conduct a preliminary inventory of performance-based program and policy initiatives.

(f) In Year 1, assess opportunities and define measures for improved performance management.

Objective 2. Accreditation Readiness: Prepare MDPH and local health boards to participate in the national voluntary accreditation program of the Public Health Accreditation Board (PHAB), designed to improve and protect the health of communities by advancing the quality and performance of public health departments:

(a) In Year 2, conduct state health assessment.

(b) In Year 2, develop state health improvement plan.

(c) In Year 3, develop state health department strategic plan.

(d) Ongoing throughout the project period, working with the five statewide public health professional associations, the Local Public Health Institute at the Boston University School of Public Health and other stakeholders, educate local Boards of Health about the PHAB accreditation process.

(e) In Year 3, apply for PHAB accreditation for state health department.

Objective 3. Quality Improvement (QI):

(a) Starting in Year 3, design and implement at least three QI projects within MDPH bureaus, or across bureaus, focused on key areas in the funding announcement and priorities that emerge during internal performance improvement assessment (Objective 1F).

(b) Starting in Year 3, conduct training for local Boards of Health (BOHs) in Quality Imrovement theory and methods, in cooperation with the five state public professional associations.

(c) Starting in Year 3, stimulate and support QI projects at a minimum of three selected local health departments targeting communities preparing for PHAB accreditation, replicating the Multi-State Learning Collaborative approach and coordinating with the five statewide professional public health associations. Incrementally increase the number of BOH QI projects in Years 4 and 5 of the project.

(3) How the proposed infrastructure investments are linked to system improvements and health outcomes: The proposed performance management and quality improvement activities target key public health challenges and opportunities in Massachusetts:

(a) Ensuring the success of health care reform: As a result of Massachusetts and federal health care reform laws, public health authorities are being tasked with a major role in helping residents prevent and manage chronic and other diseases. In 2008, the Institute of Medicine identified state and local government actions as key to front-line efforts addressing obesity prevention. A 2009 report by the National Academy of Sciences noted that, "the places in which people live, work, study, and play have a strong influence on their ability to consume healthy foods and beverages and engage in regular physical activity. Local governments make decisions every day that affect these environments."[2] And as Thomas Frieden argued in a 2004 editorial in the *American Journal of Public Health*, it is urgent that local health departments "adjust to the epidemiological transition from communicable to chronic disease."[3]

Massachusetts is proud to be a leader in such efforts. Our Mass in Motion anti-obesity campaign combines statewide action with municipal wellness and leadership grants to cities and towns to implement policy and systems strategies that address obesity, nutrition and physical activity. The city of Boston has attracted major federal and national foundation funding for

[2] National Academy of Sciences. *Local Government Actions to Prevent Obesity*. 2009. http://www.rwjf.org/files/research/20090901iomreport.pdf.
[3] Frieden, TR. Asleep at the switch: local public health and chronic disease. *American Journal of Public Health*. December 2004, Volume 94, No. 12, pp 2059-2061.

innovative programs in obesity, tobacco and asthma control. But significant parts of the state lack the public health capacity to participate meaningfully in such efforts. Some of these same communities are also those experiencing the greatest disparities in chronic disease, HIV and other health concerns such as teen pregnancy. Many of these disparities are closely associated with race/ethnicity – small aging industrial cities such as Chelsea, Holyoke and Lawrence are now majority Latino; others such as Brockton and the old fishing port of New Bedford are home to large numbers of Haitian and Cape Verdean immigrants; and Lowell is home to the second largest population of Cambodians in the nation (after Long Beach, California).

(b) *Winnable battles in improving health outcomes*: Through the QI projects to be designed and implemented within MDPH (Objective 3A) and among local boards of health, this project will target several of the CDC's "winnable battles" in public health. Three examples:

(i) Tobacco: Massachusetts has a long history of activism and leadership, which has produced real results: the state's smoking rate fell to 16.4% in 2007, the 4th lowest rate in the nation; illegal sales of tobacco were cut in half from FY 2006 to FY 2007; the youth smoking rate fell from 20.5% in 2005 to 17.7% in 2007; and with a 98% compliance rate, the Commonwealth's smoke-free workplace law has been effective at protecting Massachusetts residents from secondhand smoke. But as the tobacco industry continues to develop new products and strategies designed to increase tobacco use, tobacco control at the state and local level must continuously improve its own performance to meet the challenge. In addition, many Massachusetts communities lack the capacity to conduct compliance checks and other enforcement activities necessary to continue the momentum. As the statewide strategy shifts toward regulation of point-of-purchase advertising and potentially to aggressive in-store counter-advertising, local understanding and enforcement of the new regulations will become still more critical.

(ii) HIV/AIDS:, Through its deployment of evidence-based prevention interventions at the individual, group, and community levels, through structural interventions (such expanded access to sterile injection equipment), through routine and targeted HIV screening, and through near-universal access to medical care and effective antiviral medications (resulting from state health care reform and substantial state investment in its HIV Drug Assistance Program), Massachusetts has seen a dramatic decrease in the incidence of HIV infection and a slowing of the growth of the prevalence of HIV/AIDS. In 2001, a total of 1,237 cases of HIV infection were reported to the state HIV/AIDS Surveillance Program. In 2008, the most recent complete year of data, only 563 cases were reported, a 54% decrease. Reductions in incidence span all age, sex, and race/ethnicity categories. Reported cases among injection drug users are approaching single-digit percentages of all new cases. Remaining incidence is clustered in men who have sex with men, black and Hispanic individuals, and non-US born populations. Massachusetts is rapidly entering an elimination phase of addressing the HIV/AIDS epidemic, requiring a keen focus on these remaining pockets of infection. The state is poised to pilot innovative new strategies to further reduce this low rate of new infections, and tackle geographic and behavior-based clusters. To support such innovation, MDPH must ensure that performance management, QI and program evaluation keep up – allowing us to understand what is working and what is not, and invest in what works.

(iii) Obesity: Approximately 18 months ago, Massachusetts launched a multi-faceted campaign called Mass in Motion. This effort began with our convening of a broad-based steering committee composed of local health departments, schools, community-based agencies

(including the "Y" and Boys and Girls Clubs), academic organizations and local activists. With the assistance of this group, we reviewed the most up-to-date data, analyzed the best practices and completed an inventory of existing efforts, which highlighted key gaps. Mass in Motion combines statewide action with municipal wellness and leadership grants to cities and towns to implement policy and systems strategies that address obesity, nutrition and physical activity. Currently funded through a combination of state, foundation and corporate support, Massachusetts will be seeking additional federal funding to bring the program to more communities. To effectively expand anti-obesity efforts at both the state and local level, integrate activities across levels of government and between the governmental and non-profit sectors, performance management and QI will play a critical role in keeping the effort on target and results-oriented.

C. Activity Plan.

(1) Specific infrastructure investments, methods and activities:

Objective 1. Performance Management Leadership: The Massachusetts Commissioner of Public Health will designate Geoff Wilkinson, his Senior Policy Advisor, as the MDPH Performance Improvement Manager. Mr. Wilkinson will work with Kristin Golden, MDPH Director of Policy and Planning, and a performance improvement specialist from Commonwealth Medicine (the consulting division of UMass Medical School) to oversee and coordinate all Component I activities. Together, Mr. Wilkinson, Ms. Golden, and the performance improvement specialist will constitute a minimum 1 FTE Performance Improvement Manager. This Performance Improvement Management team will participate in national training and networking.

This team will designate Quality Management Leaders (QMLs) for each MDPH bureau, which are organized into such areas as Infectious Disease, Environmental Health, Family Health and Nutrition and Health Care Safety and Quality. The QMLs will participate in QI training, disseminate QI skills and strategies bureau-wide, assist with the preliminary inventory of performance-based programs and assessment of opportunities, and lead QI activities (Objective 3) within selected bureaus.

The inventory of performance-based program and policy initiatives is designed to better understand the range of such activities currently underway at MDPH, characterize the array of strategies and methods being used, and assess measures and results. Working from this inventory, and from other information gathered during the first phase of the project, we will conduct an assessment of opportunities for further QI activities, and define key measures for improved performance management.

Objective 2. Accreditation Readiness: MDPH is committed to meeting the voluntary PHAB accreditation standards for state public health departments, and supporting local health boards in understanding the value of accreditation and preparing for it. Accreditation is a system of common standards used to measure performance. It is based on standards that health departments can put into practice to ensure they are providing the best services possible to keep their communities safe and healthy. Accreditation will drive MDPH and local health departments to continuously improve services and performance. Other community services and organizations have seen the value of accreditation, such as schools, daycare centers, police departments and

hospitals. The PHAB national accreditation program is currently being beta-tested and is expected to be launched in 2011.

We will use the project to complete three processes defined by PHAB as prerequisites for national accreditation of state health departments: (a) *A state health assessment*, in which a health department assesses the health status and the public health needs of its population. (b) A *state health improvement plan*, based on the health assessment, which maps out what the health department is going to do as it works with partners to improve the health status of its jurisdiction. (c) A *strategic plan* for the health department, which sets forth a health department's priorities and how it plans to accomplish its strategic goals. Combined with bureau-level Quality Improvement projects to be conducted in association with Objective 3, MDPH anticipates being prepared to apply for PHAB accreditation in Year 3 of the project.

In addition, we will work with the five statewide public health professional associations, the Local Public Health Institute at the Boston University School of Public Health, and other stakeholders to educate local boards of health about the PHAB accreditation process. Local accreditation may be particular challenge in Massachusetts, which has an exceptionally fragmented local public health system. Massachusetts ranks 44th in land area among the states, but has more local health departments than any other. There are 351 separate cities and towns, each with its own Board of Health responsible for assuring access to a comprehensive set of services defined by state law and regulation. Massachusetts Boards of Health are authorized to develop, implement, and enforce health policies, oversee inspections to maintain minimum standards for sanitation in housing and food service, and assure that the basic health needs of their community are being met.[4] They are responsible for disease prevention and control, health and environmental protection, and general community health promotion. Boards of Health are legally autonomous from the Massachusetts Department of Public Health (MDPH). Local health authorities cooperate actively with MDPH and the Massachusetts Department of Environmental Protection, but local health agents are not subject to the authority of the MDPH commissioner.

In our Component II application, we propose a major regional collaboration initiative to develop at least seven public health districts covering at least 50% of the state's population. Interestingly, the three western Massachusetts communities of Amherst, Northampton and Quabbin are jointly participating as one of 30 PHAB beta test sites. The proposed Component I performance management improvement activities will strongly support the implementation of our Component II regional collaboration activities.

Objective 3. Quality Improvement (QI): Based on the inventory and assessment discussed above under Objective 1, we will design and implement several QI projects within MDPH bureaus, or across bureaus, focused on the key areas discussed in the funding announcement. Such projects might involve, for example, the Bureau of Environmental Health (food safety protection program); Bureau of Health Care Safety and Quality (hospital acquired infections); Bureau of Community Health Access and Promotion (obesity reduction); Office of General Counsel (promoting municipal policy change to advance community health); State Laboratory Institute (timely sample collection, analysis, and reporting); Bureau of Health Information, Research, and Statistics (electronic death records); or other areas such as tobacco and HIV discussed above. Dr. Howard Koh, Assistant Secretary for Health, in his Statement on Quality in the Public Health System, has identified three key QI methodologies in public health: (a)

[4] Massachusetts Association of Health Boards. http://www.mahb.org/boh.htm.

Facilitating partnerships between public and private entities focused on quality to stimulate and promote the engagement of national leaders. (b) Promoting dialogue between public health and health care organizations on improving quality as a means of developing unifying strategies to build synergy and reduce fragmentation of quality improvement efforts. (c) Enhancing the knowledge of the public health workforce to ensure that concepts of quality and quality improvement are mainstreamed into public health practice.[5] MDPH QI activities in the selected bureaus and programs with employ these three methods – partnerships, dialogue between public health and health care, and enhancing knowledge in the public health workforce.

In addition, the project will support ongoing efforts to develop capacity in local health departments, with a focus on QI activities in communities preparing for PHAB accreditation. These ongoing activities, which have focused on regional collaboration, include: (a) The Working Group on Public Health Regionalization, which came together in 2005 to examine the ways in which regional structures could be used in Massachusetts to enhance public health services at the local level. This effort has been led by the Boston University School of Public Health in conjunction with MDPH and the state's five professional public health associations, including the Mass. Public Health Association (affiliated with APHA), Mass. Health Officers Association (affiliated with NACCHO), Mass. Environmental Health Association (affiliated with NEHA), Mass. Association of Public Health Nurses, and Mass. Association of Heath Boards. Recommendations of the Working Group were recently endorsed by a task force led by the state Lieutenant Governor, which was created by the legislature to study opportunities to regionalize a wide range of municipal services, including public health. (b) The 2009 enactment of a new state law that brought about long overdue changes to rules governing how cities and towns may co-hire health staff and form public health districts in Massachusetts. (c) Funding from the Robert Wood Johnson Foundation for a Practice Based Research Network that is assisting three groups of communities in western Massachusetts to explore formation of public health districts.

(2) Key partners: Key partners include: (a) Commonwealth Medicine, the health care consulting division of UMass Medical School. Its programs have helped the Commonwealth of Massachusetts — and many state and local health care agencies — to increase the value of health care expenditures, while improving access to and delivery of care for at-risk and uninsured populations. Unlike most health care consulting firms, UMass Medical School's Commonwealth Medicine division is a public entity, with staff members uniquely prepared to meet the challenges of government agencies, nonprofits, and managed care organizations, working to fulfill its vision of providing underserved populations with access to quality health care services. Commonwealth Medicine will provide a performance improvement specialist as part of the MDPH Performance Improvement Management team, who will assist in development and coordination of major project activities. (b) The various partners in the regionalization initiative, mentioned above, include the Local Public Health Institute at the Boston University School of Public Health, the Working Group on public health regionalization and the five professional public health associations. These organizations will, in particular, support Objectives 2D (support for local public health accreditation) and 3B (local public health QI projects).

[5] Statement from Dr. Howard Koh, Assistant Secretary for Health, on Quality in the Public Health System. September 2009. http://www.hhs.gov/ophs/news/20090921.html.

(3) Cross-jurisdictional relationships. As described above, the Massachusetts Component I project specifically addresses cross-jurisdictional relationships. In particular, relationships between MDPH and local public health are the focus of Objectives 2D (support for local public health accreditation) and 3B (local public health QI projects).

(4) Staffing / Project Management: Geoff Wilkinson, senior policy advisor to the Commissioner and a member of the Department's senior management team, will be designated as Performance Improvement Manager. Mr. Wilkinson has over two decades of experience managing health and human service organizations and has participated in Performance Improvement training with the Multi-State Learning Collaborative. He currently manages the Department's initiatives to promote public health regionalization and also will have lead responsibility for Component II performance management activities, ensuring coordination between Components I and II. He will work closely with MDPH Chief Of Staff, Monica Valdes Lupi, and with Kristin Golden, Director of Policy and Planning. Ms. Valdes Lupi serves as chief deputy to the MDPH commissioner, supervises senior managers including the chief financial officer, and convenes regular meetings of the MDPH bureau directors. Ms. Golden supervises the MDPH chief information officer and the director of the Bureau of Health Information, Research and Statistics. Project management will utilize Performance Improvement methods to integrate activities across bureaus and to track progress on key objectives. Currently scheduled senior management team meetings will provide a regular forum for project coordination.

D. Performance Plan.

Objective	Milestones	Outcome Indicators
1. Performance Management Leadership	- By Month 1, designate the MDPH Commissioner's senior policy advisor as Performance Improvement Manager, working with the MDPH Director of Program and Policy and a performance improvement specialist from Commonwealth Medicine to oversee and coordinate all Component I activities. - By Month 4, designate bureau-level Quality Management Leaders (QMLs). - Starting in Month 6, conduct quality improvement training for the MDPH senior management team, bureau directors and QMLs. - Participate in national training and networking, ongoing throughout the project period. - By Month 9, conduct a preliminary	Management leadership team identified 3 trainings conducted for MDPH senior management Written inventory of current performance based programs Written inventory of proposed new performance management meaures

Objective	Milestones	Outcome Indicators
	inventory of performance-based program and policy initiatives. - In Year 1, assess opportunities and define measures for improved performance management.	
2. Accreditation Readiness	(a) In Year 2, conduct state health assessment. (b) In Year 2, develop state health improvement plan. (c) In Year 3, develop state health department strategic plan. (d) Ongoing throughout the project period, educate local boards of health about the PHAB accreditation process. (e) In Year 3, apply for PHAB accreditation..	Written state health assessment Written state health improvement plan Written state health department strategic plan At least 6 regional BOH trainings on PHAB accreditation process Application for PHAB accreditation of state health department
3. Quality Improvement	(a) Starting in Year 3, design and implement at least 3 QI projects within MDPH bureaus, or across bureaus. (b) Starting in Year 3, stimulate and support QI projects at a minimum of three selected local health departments targeting communities preparing for PHAB accreditation. (c) Starting in Year 3, conduct QI training with Boards of Health, in cooperation with state public health professional associations..	Measured performance improvements in targeted MDPH bureaus Measured performance improvements in selected BOHs At least 5 QI trainings for BOHs.